CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

During the 1993 and 1995 sessions, the Virginia General Assembly passed legislation related to assisted living facilities (ALFs) requiring that Auxiliary Grant (AG) recipients be evaluated by a case manager or other qualified assessor to determine their needs for residential care. The Code of Virginia (§§ 63.1-173.3) was amended to require that a uniform assessment instrument be completed upon admission and at subsequent intervals as determined by regulations of the Board of Social Services for each resident of an ALF.

The 1993 General Assembly also amended §§ 63.1-172 *et seq*. of the Code of Virginia, establishing two-tiered licensing for ALFs: residential and assisted living. The amendment defined requirements that the ALF must meet in order to be licensed as an assisted living facility that will provide a level of service for individuals who may have physical or mental impairments and who require at least a moderate level of assistance with activities of daily living. The Department of Medical Assistance Services (DMAS) also requested a home- and community-based services waiver to provide coverage for persons who are determined to be at risk of nursing facility placement in the near future, but can receive the necessary care in an assisted living facility.

In order to reimburse ALFs for the cost of providing services to residents who require assisted living services, a new reimbursement system was developed to supplement the Auxiliary Grant program. An Auxiliary Grant is a grant payment to eligible ALF recipients to pay for the cost of basic residential services (room, board, basic supportive services, and supervision). In addition, if an Auxiliary Grant recipient requires assisted living services, DMAS will make a vendor payment to the ALF for one of the two levels of assisted living services (regular assisted living and intensive assisted living services). The 1996 General Assembly added language and funds to allow DMAS to provide regular assisted living payments only for eligible individuals receiving General Relief payments in public homes for adults in the same manner as eligible individuals receiving Auxiliary Grant payments. The level of care required by the public pay resident will be determined by a case manager or other qualified assessors using the Uniform Assessment Instrument (UAI).

DMAS is responsible for those aspects of the legislation related to payment of assessments, targeted case management, and assisted living services for Auxiliary Grant or General Relief residents (as applicable) of an ALF. In addition, DMAS is responsible for monitoring the services provided. The Virginia Department of Social Services (VDSS) is responsible for licensing ALFs, monitoring compliance with standards, and ensuring that all residents are assessed.

All ALF residents and applicants must be assessed using the UAI to determine the need for residential or assisted living. In addition, all ALF residents must be reassessed using the UAI whenever there is a change in the level of care needed. Under Medicaid-funded targeted ALF case management services, Auxiliary Grant residents will receive a twelve-month reassessment only or ongoing targeted ALF case management services, or both. Ongoing Medicaid-funded ALF targeted case management services are also provided

to Auxiliary Grant residents who have multiple needs ALF across multiple providers when the ALF cannot provide the services but they are available in the community.

This chapter describes assessment and authorization for assisted living services, coverage criteria, and the policies and procedures for the implementation of assisted living services in ALFs. Two types of assisted living services have been available to recipients of Auxiliary Grants residing in ALFs. They are:

- **Regular assisted living services** for those individuals who do not meet the criteria for waiver services but who require at least a moderate level of assistance with activities of daily living; and

- **Intensive assisted living services** for those individuals who meet the level of care criteria for waiver services.

As of March 17, 2000, the Health Care Financing Administration (HCFA) terminated the IAL Waiver. However, all residents in the waiver prior to termination will continue to be in the waiver until they change to another level of care or expire. The 2000 Session of the Virginia General Assembly also changed the name "adult care residence" to "assisted living facility."

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing or coordinating, or both, the services necessary to meet all of their health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. The PCP's name and telephone number are listed on the recipient's MEDALLION identification card. Refer to the MEDALLION section of this manual for further details on the program.

MEDALLION II

In areas where the Medallion II program is available, the majority of Medicaid recipients receive primary and acute care through mandatory enrollment in Health Maintenance Organizations (HMOs). There are at least two HMOs per area that have contracts to serve Medicaid recipients. Effective January 1, 1996, the program initially covered Medicaid populations located in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Poquoson, and Virginia Beach. Effective November 1, 1997, Medallion II expanded to cover populations located in the counties of York, James City, Gloucester and the Isle of Wight and the cities of Williamsburg and Suffolk. Effective April 1, 1999, populations

located in the Richmond metropolitan area, Eastern Shore, and Southwest Tidewater regions were covered.

AUXILIARY GRANT PROGRAM

The Auxiliary Grant Program is a state and locally funded assistance program to supplement the income of a recipient of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in a licensed ALF. This is assistance available from local departments of social services to ensure that recipients are able to maintain a standard of living which meets a basic level of need. Before an individual can receive assistance from the Auxiliary Grant program, eligibility for the program must be determined by the local department of social services (LDSS) where the individual resides. Residence for Auxiliary Grant eligibility is determined by the city or county within the state where the person last lived outside of an institution or adult family care home. Any records or statements can be used to determine place of residence. If residency cannot be determined, or if the individual is from out-of-state, residency is where the individual is living at the time of application. If the individual is entering the ALF from a state institution, the application is to be filed in the locality where the individual resided before he or she entered the state institution.

Entitlement to Auxiliary Grant assistance begins the date on which all eligibility criteria for the program are met.

All applicants for an Auxiliary Grant must have an assessment completed before Auxiliary Grant payment can begin. Verification of the initial assessment or assessment for a change in level of care will be a completed DMAS-96, Long-Term Care Pre-Admission Screening Authorization, sent to the appropriate LDSS eligibility worker by the assessor. At the time of the resident's twelve-month reassessment, the assessor completes the ALF Eligibility Communication Document (Appendix C). This form tells the LDSS eligibility worker that the resident continues to meet either residential or assisted living so that Auxiliary Grant eligibility can be redetermined.

Auxiliary Grant-eligible recipients will also be eligible for Medicaid payment of their health care needs such as hospital, pharmacy, and physician services.

GENERAL RELIEF PROGRAM

General Relief means money payments and other forms of relief made to eligible persons as established by the LDSS boards in accordance with the rules and regulations of the State Board of Social Services. Application for assistance is made to the local board and filed with the local superintendent of the county or city in which the applicant resides. For purposes of receiving regular assisted living services payment, these recipients must reside in a public home for adults in Waynesboro or Manassas.

General Relief recipients residing in an ALF will not be Medicaid-eligible for payment of their health care needs. Therefore, the DMAS-funded ALF intensive assisted living and Medicaid-funded targeted case management services are not available to this population. However, DMAS will reimburse assessment agencies for the initial and subsequent

assessments and will reimburse the public homes for the provision of regular assisted living services.

CASE MANAGEMENT

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or

2. Ongoing targeted ALF case management.

It is believed that most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment and not ongoing targeted case management services.

Who Can Provide Medicaid-Funded ALF Case Management?

To qualify as a provider of case management, the provider of services must ensure that all case management staff meet minimum qualifications. The case manager must possess a combination of work experience and relevant education which indicates that the individual possesses the knowledge, skills, and abilities related to the provision of assessment and case management services. Medicaid-funded case management services for Auxiliary Grant ALF residents can be provided by:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards; and
- Local departments of health.

Twelve-Month Reassessment

The purpose of the twelve-month reassessment is the re-evaluation of service need and utilization review. The assessor shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. The outcome of this review shall be communicated to the LDSS eligibility staff, DMAS, the facility where the resident resides, and the resident. All ALF residents must be reassessed at least annually. All applicants for an Auxiliary Grant must have an assessment completed before Auxiliary Grant payment can be issued.

The twelve-month reassessment is completed by the assessor conducting the initial assessment. If the original assessor is neither willing nor able to complete the assessment and another assessor is not available, or if the individual moves, then the local department of social services where the resident resides, following placement in an ALF, is the assessor

(except for residents receiving Medicaid-funded mental health or mental retardation case management services).

When initial assessments are completed by acute-care hospital staff, state facility staff, or a physician who may be a qualified assessor, but who will not have twelve-month reassessment or case management responsibilities, the assessor completing the initial assessment must refer these responsibilities to another assessor as soon as possible, but no later than one month prior to the due date of the twelve-month reassessment.

If the resident is receiving targeted case management services for mental illness or mental retardation, the case manager for this service must complete the reassessment as part of the case management responsibilities for that individual.

Ongoing Medicaid-Funded Targeted ALF Case Management Services

Ongoing Medicaid-funded targeted ALF case management is a service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and

2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and

3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the assessor must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The case manager for ongoing targeted ALF case management is responsible for:

1. The completion of the UAI, either short assessment or full assessment, as appropriate (the twelve-month reassessment is considered one of the quarterly contacts);

2. Any change in level of care, as appropriate;

3. Developing the plan of care that addresses needs on the UAI (which cannot be met by the ALF) and maintaining the log of contacts.;

4. Implementing and monitoring the plan of care, including arranging, coordinating, and monitoring services;

5. Monitoring the ALF's Individualized Service Plan (which addresses needs that are set by licensing standards) for the resident and other written communications concerning the care needs of the resident;

6. A quarterly visit with the resident or his or her representative to evaluate the resident's condition, service needs, appropriate service placement, and satisfaction with care;

7. Serving as the contact for the ALF, family, MEDALLION PCP, the HMO case manager, and other service providers to coordinate and problem solve; and

8. Assistance with discharge, as necessary.

Medicaid-funded ongoing targeted case management services are not available to General Relief residents because these residents are not Medicaid eligible.

Because they are not local public human service agencies, acute care hospitals, state mental health/mental retardation facilities, and private physicians may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments only.

MEDICAID-FUNDED SERVICES IN ALFS

ALFs are licensed by VDSS to provide care and maintenance to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with 1) activities of daily living (ADLs), 2) instrumental activities of daily living (IADLs), 3) administration of medication, or, 4) supervision due to behavioral problems, or all, but does not require the level of care provided in a nursing facility.

ASSESSMENT AND AUTHORIZATION

Services will be offered only to individuals who have been certified as eligible for assisted living services by an assessor. The assessor will evaluate the individual's functional and medical needs and authorize services to meet those needs. Payment for assisted living services is only available for recipients residing in a licensed assisted living facility which has a valid DMAS provider agreement. The assessor must notify the appropriate LDSS eligibility staff upon completion of the UAI that the recipient has been authorized for assisted living and must forward the UAI and authorization forms to DMAS, the assisted living facility chosen by the recipient, and to the case manager, if case management services have been authorized. The assessor must give all recipients who have been denied assisted living services written notification that services have been denied and give the recipient the right to appeal the decision.

<u>Definition of Assessment</u>

An assessment is a standardized approach using common definitions to gather sufficient information on applicants to and residents of ALFs to determine their care needs, and, for

Auxiliary Grant and General Relief recipients, to determine their need for residential care. Assessment is the prior authorizing mechanism for public reimbursement for ALF services.

Since July 1, 1994, most publicly funded human service agencies in Virginia, including the local departments of social services, area agencies on aging, community services boards, centers for independent living, state facility staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and Medicaid Nursing Home Pre-Admission Screening Committees have been using one common assessment, the UAI, to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring resident care needs ALF across agencies and services. The UAI is comprised of a short assessment, designed to be an intake/screening document and a full assessment, designed to be a comprehensive evaluation. The completion of the short or full UAI is based on the initial review of the individual's needs and which long-term care service has been requested. A training manual entitled *User's Manual: Virginia Uniform Assessment Instrument* provides thorough instructions regarding completion of the assessment (a copy of this manual is available from DMAS).

Assessment of ALF applicants and residents is a process to:

1. Evaluate the medical, nursing, developmental, psychological, and social needs of each individual seeking ALF admission and continued placement;

2. Analyze what specific services the individual needs; and

3. Determine the level of care required by the individual by applying the criteria for ALF care.

The assessment of the availability of ALF services depends upon:

1. Whether an ALF licensed to meet the needs of the individual exists in the community;

2. Whether financial eligibility can be established; and

3. Whether the ALF states that it can meet the individual's needs.

<u>Assessors for Auxiliary Grant or General Relief (Public Pay) Individuals</u>

Initial assessments and authorization for assisted living services will be provided by an assessor. An assessor may be a case manager employed by a public human service facility or other qualified assessor who has a contract with DMAS to complete the assessment for residents of ALFs. The assessor will notify the recipient, the ALF, DMAS, and the eligibility worker in the local department of social services of the results of the assessment. Auxiliary Grant and General Relief residents will also receive annual reassessments, and Auxiliary Grant residents may receive targeted case management services from the case managers employed by the public human service agencies. Assessments must be completed by the assessor whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care.

For public pay individuals, assessors include the following:

- **Local departments of social services --** There are 122 local departments of social services (LDSS) which serve as a service entry point for customers. Local agency staff are responsible for determining eligibility for participation in assistance programs. LDSS staff are authorized to make payments to customers and vendors for services and provide direct services and family-focused case management to customers. Adult services targets persons over age 60 and persons 18 and over with disabilities and their families when appropriate. Goals include maximization of self-sufficiency, prevention of abuse, neglect, and exploitation, a reduction and delay in premature or unnecessary institutionalization, and aid when such placement is appropriate. Home-based services offered by LDSS include companion, homemaker, and chore services; other services which may be offered include adult day care, developmental day programs, adult foster care, and nutrition programs. LDSS also participate on the Nursing Home Pre-Admission Screening Team with local health departments and can authorize Medicaid-funded nursing facility or community-based care services. Staff of the VDSS Division of Licensing Programs license ALFs, monitor compliance with licensing standards, and ensure that all ALF residents are assessed at admission, at least annually, and as needed.

- **Area agencies on aging --** The mission of the area agencies on aging (AAAs) is to develop or enhance comprehensive and coordinated community-based systems of services for the elderly in their designated planning and service areas. Such systems are designed to assist older persons in leading independent, meaningful, and dignified lives in their own homes and communities as long as possible. Each AAA serves a specific geographic area known as the planning and service area (PSA). The 25 AAAs serve all jurisdictions in the state. AAAs provide services directly or through contracts with other community service providers.

- **Centers for independent living --** Centers for independent living (CILs) provide peer counseling, information and referral, independent living skills training, and advocacy to people with all types of disabilities. There are ten private non-profit centers in Virginia operated primarily by people with disabilities. An eleventh independent living program is operated by the Department of Rehabilitative Services at the Woodrow Wilson Rehabilitation Center.

- **Community services boards --** Community services boards (CSBs) deliver mental health, mental retardation, and substance abuse services. CSBs provide these services in the most accessible, responsible, and appropriate, yet least restrictive setting possible. There are 40 CSBs that provide some services in all 136 cities and counties in Virginia. Boards function not only as service providers, but also as client advocates, community educators and organizers, program developers and planners, and advisors to their local governments, serving as the locus of fiscal and programmatic accountability.

- **Local departments of health --** There are 119 local health departments, including every city and county in the Commonwealth. They are responsible for local health initiatives which vary according to the needs of the community. Some local health departments sponsor home health programs. Each local health department belongs to a district health department. Local health departments also participate on the Nursing Home Pre-Admission Screening Committee with local departments of social services and can authorize Medicaid-funded nursing facility or community-based care services.

- **State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services --** There are 15 state facilities in the Commonwealth which provide inpatient services for persons with mental illness or mental retardation.

- **Acute care hospitals --** There are 130 hospitals in the Commonwealth, many of which contract with DMAS to perform nursing home pre-admission screening (NHPAS) or to complete the UAI for a home- and community-based waiver program.

- **An independent physician contracting with DMAS to complete the UAI for ALF applicants and residents --** An independent physician is a physician chosen by the ALF resident, who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence. The assessment responsibilities of the physicians may be implemented by nurse practitioners, physician's assistants, or staff with the knowledge, skills, and abilities of a case manager, as assigned by the supervising physician. Physicians must sign the assessment and the authorization documents.

<u>Assessments: Who Must Be Assessed?</u>

- ALL residents of and applicants to ALFs must be assessed, regardless of payment source or length of stay.

- New admissions to ALFs must be assessed **prior** to admission.

<u>Assessments: What Is to Be Completed for Public Pay?</u>

- Short UAI assessment (first 4 pages of the UAI) and medication administration (page 5) and behavior pattern (page 8) for residential clients.

- Full UAI assessment for all assisted living clients.

Assessments: Who Pays for Assessments?

For public pay residents of ALFs, DMAS will reimburse assessors $25 for a short assessment and $100 for a full assessment. DMAS also will reimburse $25 for the 12-month short assessment and $75 for the 12-month full assessment.

Assessments: When to Complete the UAI

1. **The UAI must be completed by an assessor within 90 days prior to the date of admission to the ALF.** No one can be admitted to an ALF without having been assessed prior to admission except in the case of a documented emergency placement. A Virginia adult protective services worker or case manager for public-pay individuals can document and approve emergency placement.

2. **The UAI must be completed or updated by an assessor at least once every 12 months on all ALF residents.** The twelve-month reassessment is based upon the date of the last assessment (e.g., original assessment, twelve-month reassessment, or assessment for change in level of care) and does not need to be performed in the same month as the financial eligibility redetermination which is performed by the LDSS in the locality in which the individual resided prior to ALF placement. The financial eligibility worker must have documentation in the eligibility record that there is a current assessment on file (a current assessment is one that is not older than 12 months). **The ALF must coordinate with the assessor to determine that the annual reassessment is completed as required.**

3. **The UAI must be completed or updated as needed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care.**

The full assessment must be completed for any recipient who receives assisted living services.

Assessment Agency Responsibilities

Each assessment agency is responsible for completing the following tasks:

- To determine if the individual to be assessed is already Auxiliary Grant or General Relief or has made application to the appropriate LDSS for an Auxiliary Grant or General Relief;

- To complete the assessment process within two weeks of referral;

- To determine the appropriate level of care, determine that the individual has no prohibited conditions, and authorize service on the Medicaid Long-Term Care Pre-Admission Screening Authorization (DMAS-96);

- To contact the ALF of the individual's choice. (Determine if the ALF license matches the individual authorization and can meet the individual's needs.);
- To submit the paperwork to all entities as directed;
- To refer the individual for psychiatric/psychological examination, if appropriate; and
- To plan for the required 12-month reassessment (make referrals if appropriate);

New Assessments Not Needed: Current Assessment Completed within 12 Months (and No Change in Level of Care)

- **Lapse in financial eligibility:** If a resident becomes ineligible for an Auxiliary Grant based on income or countable resources, the LDSS eligibility worker will issue a notice of adverse action to the recipient 11 days in advance of the action to terminate the Auxiliary Grant. However, if the resident becomes financially eligible again, a new UAI will not be needed if the current UAI is less than 12 months old.

- **Transfer from one ALF to another ALF:** When an individual residing in an ALF transfers to another ALF in the Commonwealth, he or she is not required to be reassessed at the time of the transfer unless there has been a significant change in the person's condition that would warrant a change in level of care. The ALF from which the individual is transferring must send a copy of the most current UAI and Long-Term Care Authorization form (DMAS-96) to the receiving facility and notify the individual's assessor. The assessor is responsible for ensuring that the appropriate local eligibility worker receives notice of the transfer. The receiving ALF then must initiate the appropriate documentation and submit it to DMAS for admission certification purposes.

- **Admitted to a hospital from an ALF:** When the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge, a new UAI is not needed. If an individual is admitted from an ALF and the individual needs to transfer to Medicaid-funded community-based care, an assessment must be completed according to the nursing home pre-admission screening policies and procedures. If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, an assessment is not required. The second ALF must get the necessary documentation (UAI and DMAS-96) from the initial facility, complete an individualized service plan, and submit the required paperwork to DMAS.

- **Individuals assessed and awaiting ALF placement:** At times, an individual who has been assessed as appropriate for ALF care will have to remain in the community while waiting for an ALF bed. Once a placement becomes available, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the resident's condition. If more than 90 days have elapsed, a new assessment will be required.

Changes in Level of Care Assessments

Changes in level of care can be completed by all entities qualified to perform initial assessments. The change in level of care assessment must be conducted within two weeks of receipt of the request for assessment when a permanent change in level of care is indicated, including when the resident presents with one or more of the prohibited conditions as described in this chapter. **Temporary changes in an individual's condition that can be reasonably expected to last less than 30 days do not require a new assessment or update.** Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, and a well-established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

When a level of care for a public pay resident has changed as documented on the UAI, the assessor must immediately notify the financial eligibility worker of the date of the assessment. If there is a change in level of care, and the ALF is licensed for the new level, then the ALF would receive payment for the new level of care based on the effective date of authorization on the Long-Term Care Pre-Admission Screening Authorization (DMAS-96). In order to receive this payment, the ALF must submit a copy of the new DMAS-96 (completed by the assessor) and the ISP (completed by the ALF) to DMAS as required by the admission certification procedures.

Other Special Assessment Factors

- **Private Pay Conversion to Auxiliary Grant recipient --** When a private pay resident becomes an Auxiliary Grant recipient, the LDSS eligibility worker will advise the resident of program requirements. All assessment procedures must be followed. The LDSS eligibility worker must be provided with a copy of the Long-Term Care Pre-Admission Screening Authorization (DMAS-96) for verification of the assessment. If there is a "public pay" UAI assessment completed by a public pay assessor on record that is less than 12 months old, the resident does not need to be reassessed unless there is an indication that his or her level of care has changed. The alternate private pay version of the UAI cannot be used to meet the assessment requirement.

- **Independent assessments --** At the request of the ALF, the resident's representative, the resident's physician, VDSS, or the local department of social services, an independent assessment using the UAI can be completed to determine whether the resident's care needs are being met in the current placement. An independent assessment is an assessment that is completed by an entity other than the original assessor; this may be another assessor within the same agency. The ALF must assist the resident in obtaining the independent assessment as requested.

- **Out-of-state individuals --** Individuals who reside out of state and wish admission to Virginia ALFs must be assessed and authorized prior to public reimbursement for these services. When an out-of-state individual seeks ALF placement in Virginia, the LDSS or other public human service assessor in the locality of the ALF accepts the application for an Auxiliary Grant and completes the assessment. Information may be obtained by

telephone interview if a face-to-face interview is not practical, with a follow-up on-site visit within seven days after the admission.

- **Emergency placements** -- In emergency placements, the UAI must be completed within seven working days from the date of placement. An emergency is a situation in which an adult is living in conditions which present a clear and substantial risk of death or immediate and serious physical harm to self or others. Prior to the placement, the need for an emergency placement must be documented and approved by a Virginia adult protective services (APS) worker or case manager for public pay individuals. This is the **only** instance in which an individual may be placed in an ALF without first having been assessed to determine if he or she meets ALF level of care. Once the individual has been placed, assessments and case management procedures must be followed. The assessment must be completed by an appropriate assessor in the jurisdiction where the individual lived prior to the emergency placement.

- **Individuals discharged from an ALF to Medicaid-funded nursing home or home and community-based care services:** The Nursing Home Pre-Admission Screening (PAS) Committee in the locality of the ALF is responsible for assessment and authorization for individuals who are ALF residents and who may need nursing home or personal care services. The ALF will schedule with the PAS Committee to complete a screening for any individual whose needs can no longer be met in the assisted living facility. The PAS Committee handles this referral as it would a referral coming from anywhere else in the community. If the individual is in the hospital, the hospital PAS Committee can complete the assessment and authorization process for other Medicaid-funded long-term care services.

DMAS-FUNDED SERVICES IN ALFS

In general, the criteria for assessing an individual's eligibility for public payment for ALF care and services consist of the following:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living (ADLs) or instrumental activities of daily living (IADLs);

2. Medication administration; and

3. Behavior pattern/orientation.

To qualify for public payment for ALF care, an individual must meet the criteria described below and also in Appendix B.

Criteria for Residential Living **(Included for reference only as this is not a Medicaid program. ALFs do not submit paperwork to DMAS for these residents.)**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating or feeding, or both) (page 4 of the UAI);

2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of the UAI); or

3. Rated dependent in medication administration (page 5 of the UAI).

Auxiliary Grant-eligible recipients residing in ALFs on February 1, 1996, may remain in the facility even though they currently do not meet the residential living criteria.

Criteria for Regular Assisted Living

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs (page 4 of the UAI); or

2. Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of the UAI).

Criteria for Intensive Assisted Living Waiver

Individuals can no longer be authorized to receive IAL services as of March 17, 2000. However, the ALF is responsible for continued provision of this level of care for recipients who were enrolled prior to this date. Individuals meet the criteria for intensive assisted living waiver services when determined to be at risk of nursing home placement in the absence of community-based waiver services such as those that might be provided in an assisted living facility and the individual's functional capacity as documented on the UAI is described by one of the following:

1. Rated dependent in four or more of seven ADLs (page 4 of the UAI);

2. Rated dependent in two or more ADLs and rated as semi-dependent or dependent in a combination of behavior pattern (i.e., abusive, aggressive, or disruptive) and orientation (page 8 of the UAI); or

3. Rated semi-dependent in two or more ADLs and dependent in a combination behavior and orientation.

PROHIBITED CONDITIONS

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. **If any of these conditions are present, the assessor must document that they are present on the UAI, and the Auxiliary Grant or General Relief recipient or applicant is not eligible for ALF placement.** State law prohibits admission or retention of individuals in an ALF when they

have any of the following conditions or care needs (**bold text is used to indicate language from the law**):

1. **Ventilator dependency:** A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.

2. **Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing and care is provided by a licensed health care professional under a physician's treatment plan:** Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The following is a summary of dermal ulcer stages:

   Stage I A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved;

   Stage II A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater;

   Stage III A full thickness of skin loss, exposing the subcutaneous tissues (presents as a deep crater with or without undermining adjacent tissue); and

   Stage IV A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

3. **Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia:** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks.

   Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein: Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parental nutrition (TPN). Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician’s treatment plan.

4. **Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**

5. **Psychotropic medications without appropriate diagnosis and treatment plans:** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotics, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Dalmane, Valium, Thorazine, Librium, Tranxene, Ativan, Xanax, Vistaril, Atarax, Restoril, Amytal, Mellaril, Haldol, and Clozaril.

6. **Nasogastric tubes:** A nasogastric tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.

7. **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube:** Gastric tube feeding is the use of any tube that delivers food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).

8. **Individuals presenting an imminent physical threat or danger to self or others:** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the resident.

9. **Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day):** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Residents requiring continuous licensed nursing care may include:

    a. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or

    b. Individuals with a health care condition with a high potential for medical instability.

10. **Individuals whose physician certifies that placement is no longer appropriate**.

11. **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the *State Plan for Medical Assistance* -- Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.**

12. **Individuals whose health care needs cannot be met in the specific ALF as determined by the residence**.

The ALF must plan for the discharge of any resident who has a prohibited condition.

AUTHORITY FOR AUTHORIZATION OF DMAS PAYMENT

After the assessor has completed an assessment and established a level of care, the assessor is responsible for authorizing the appropriate services. During the authorization process, the assessor, with input from the individual being assessed, will decide: what services, if any, are needed; who will provide the services; and the setting where services will be provided. The assessor will identify the available community services and make referrals as appropriate. The appropriate level of care must be documented on the Long-Term Care Pre-Admission Screening Authorization (DMAS-96).

Assessors have the responsibility and authority for authorizing DMAS reimbursement for ALF services. In those instances when the assessment documentation does not **clearly** indicate that the individual meets ALF criteria, DMAS funding for these services cannot be authorized. Any information needed to support the assessor's level-of-care decision must be documented on the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement and thus can overturn any decision made by the assessor. Any authorization made by the assessor is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the service provider initiates contact with the individual.

The possible results from ALF assessment may include:

1. A recommendation for ALF care;

2. Referral to a Nursing Home Pre-Admission Screening Committee to review whether the individual is appropriate for Medicaid-funded community-based care or nursing home care;

3. Referrals to other community resources (non-Medicaid-funded) such as home health services, adult day care centers, home-delivered meals, etc.; or

4. Referral for services not required.

ACTIONS TO BE TAKEN UPON COMPLETION OF THE ASSESSMENT

Prior to placement in an ALF, the assessor contacts the ALF to discuss the level of care needed and to ensure that the ALF has the appropriate licensing and is enrolled as a Medicaid provider. The assessor must also discuss with the ALF staff the types of services needed by the applicant and determine whether the ALF is capable of providing the required services or whether they are available in the community.

When care of a resident's special medical needs is provided by licensed staff of a home-care agency, the ALF staff may receive training from the home-care agency staff in appropriate treatment monitoring techniques regarding safety precautions and emergency actions. If a public pay resident has special needs that can be provided by a home health agency, DMAS may reimburse for these services after a review to determine if the services fall within DMAS' guidelines for home health services. Recipients with a prohibited condition cannot stay in an ALF, and DMAS will not reimburse for home health services in this case.

Once the placement is finalized, the assessor notifies the LDSS financial eligibility worker responsible for determining the Auxiliary Grant payment of the effective date of admission using the Long-Term Care Pre-Admission Screening Authorization (DMAS-96).

FREEDOM OF CHOICE

For public pay individuals, the assessor or case manager, if applicable, **must** offer the individual the choice of service provider(s), including case managers and ALFs, that may be needed. When ongoing Medicaid-funded targeted ALF case management is needed, these choices must be documented on the Plan of Care. The individual's choice of providers is a federal requirement. Freedom of choice must be documented in the individual file of the recipient.

RIGHT OF APPEAL

Assessors must advise, orally and in writing, all applicants to and residents of ALFs for which assessment or targeted case management services are provided of the right to appeal the outcome of the assessment, the twelve-month reassessment, or determination of level of care. Auxiliary Grant applicants who are denied Auxiliary Grants because the assessor determines that they do not require the minimum level of services offered in the residential care level have the right to file an appeal with VDSS. A determination that the individual does not meet the criteria to receive assisted living services, intensive assisted living services, or Medicaid-funded ALF targeted case management services is an action which is appealable to DMAS.

FORMS REQUIRED FOR ADMISSION TO ASSISTED LIVING SERVICES

The assessor who is initiating a referral must call the provider first to notify him or her that the recipient has chosen his or her facility for services and to determine if the provider is able to initiate services promptly for the recipient. If the provider can accept the referral, the assessor will send the provider a complete packet required for the facility to admit the recipient to services.

If the provider does not receive an entire, thoroughly completed packet of referral forms from the assessor, as noted below, the provider must notify the responsible assessor and request the complete packet. A provider **will not** be reimbursed for services without the copy of the Long-Term Care Pre-Admission Screening Authorization (DMAS-96), completed by the assessor,

The forms which must be thoroughly completed by the assessor and forwarded to the ALF are:

- A full **Uniform Assessment Instrument** (UAI) completed by the assessor (the ALF will put a copy in the resident's record); and

- The **Long-Term Care Pre-Admission Screening Authorization** (DMAS-96) completed by the assessor (the ALF will put in the resident's record and send a copy to DMAS, along with a copy of the individualized service plan). The authorization must be completed for the appropriate level of care and must be signed and dated by the assessor prior to the start of services.

Assessors will make assisted living services referrals only to facilities which have met DMAS requirements and are enrolled under contract as a DMAS assisted living services provider.

ASSISTED LIVING PROVIDER RESPONSE TO REFERRAL

The provider shall not begin services for which Medicaid reimbursement is expected until the admission packet is received from the assessor and not before the date authorized by the assessor on the DMAS-96.

It is the provider's responsibility to determine whether the facility can adequately provide services to an individual prior to accepting a referral for services.

ADMISSION CERTIFICATION PROCESS/RESPONSIBILITIES OF THE ALF

The ALF must forward a copy of the Long-Term Care Pre-Admission Authorization form (DMAS-96) completed by the assessor and the ISP completed by the facility to DMAS for authorization to bill DMAS for regular assisted or intensive assisted living services. All authorizations for assisted living services are subject to the approval of DMAS prior to Medicaid payment. Copies of all documents must also be retained by the provider in the resident's record.

Assisted living recipient enrollment packets must be sent to the following address:

Assisted Living Admission Certification
Long-Term Care and Quality Assurance Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Do not submit the enrollment packages to DMAS without the recipient's Medicaid number (12 digits) and the ALF provider's Medicaid number (7 digits).

DMAS RESPONSIBILITIES

Once all information is received and reviewed, the analyst will enter the authorization for assisted living services into the DMAS computer system and will send the provider

confirmation of the enrollment so that the facility can bill DMAS for services rendered. Any incomplete enrollment packets will be returned to the provider for completion. After the enrollment analyst enters the information into the computer, the facility will receive a computer-generated letter which confirms that the recipient is enrolled to the DMAS system for payment of assisted living and the date of service Medicaid payment can begin. If there are any questions regarding this letter or the information provided, contact DMAS immediately at 804-225-4222. The facility cannot bill for services until this letter is received.

Effective Date for DMAS Payment of Assisted Living Services

DMAS will pay the facility for service rendered while the recipient is both: a) determined, in accordance with regulations published by VDSS, to be eligible for benefits under the Auxiliary Grant program, and b) authorized for a level of assisted living. The assisted living authorization is considered effective as of the date the authorization form is signed and dated, except in the following situations:

1. In the case of an emergency placement as defined in VDSS regulations, the assisted living authorization shall be considered effective as of the date of the emergency placement, provided that the authorization form is signed and dated within seven working days after the date of the emergency placement.

2. **Documentation of a resident's level of care must be readily apparent to the assessor and found in the resident's record, such as the ISP or a UAI completed by the facility. If the documentation does not support the recommended level of care prior to the assessor's on-site visit, the authorization is considered to be the effective date the authorization is signed and dated.**

In addition, in order for assisted living payments to be made to a facility, the assisted living authorization must be based on a UAI which complies with the requirements of the Code of Virginia, § 63.1-173.3.

An Auxiliary Grant resident may not receive assisted living services concurrently with any other Medicaid-funded in-home or residential support waiver services authorized under § 1915(c) of the Social Security Act.

RESPONSIBILITIES OF THE ALF FOR MONITORING OF RECIPIENT SERVICES

The ALF is responsible for ensuring that an assessment is conducted prior to the individual's admission to determine if he or she meets ALF criteria. The ALF must coordinate with the assessor to ensure that the assessment is completed as required. Except in the event of a documented emergency, all individuals must be assessed to determine necessity for ALF placement **prior to** the placement. Assessments that have been completed within 90 days prior to the individual's admission to the ALF are acceptable.

The ALF must keep all assessments and related documentation in the resident's record. The ALF must comply with the standards and regulations of the VDSS Division of Licensing Programs.

VDSS assessment regulations require that the ALF staff know the criteria for the levels of care in an ALF and be responsible for arranging for the discharge of the resident whenever a resident does not meet, either upon admission or at any later time, the criteria for level of care for which the ALF is licensed. Discharge is the process that ends the stay in an ALF. ALF staff must plan for post-discharge services when the resident is returned to a home-based placement, a nursing home, or facility operated by DMHMRSAS. ALF staff must notify the LDSS financial eligibility worker in the jurisdiction responsible for authorizing the Auxiliary Grant of the date of discharge and also notify the case manager, if applicable.

The ALF is responsible for monitoring the ongoing provision of services to each recipient. This includes:

- The quality of care provided by the ALF;
- The functional and medical needs of the individual and any modification necessary to the ISP due to a change in these needs; and
- The individual's need for support in addition to care provided by the facility. This includes an overall assessment of the individual's safety and welfare in the facility.

ALF Staff Responsibilities

The ALF staff are responsible for following the ISP, notifying the licensed health care professional of any change in condition or support or problem that arises, and documenting the performance of duties in the recipient's record. The ALF staff must document in the recipient's record the specific services delivered to the recipient and the recipient's response. ALF staff comments must include observation of the recipient's physical and emotional condition, daily activities, and response to services rendered.

Any corrections to the recipient's record should be made by drawing a line through the incorrect entry and reentering the correct information. All corrections must be initialed and dated. **Whiteout must never be used for correction.** Copies of all recipient records are subject to review by state and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times.

INDIVIDUALIZED SERVICE PLAN (ISP)

The licensee/administrator or designee, in conjunction with the resident, and the resident's family, case worker, case manager, licensed health care professional, and other health care providers or other persons, as appropriate, shall develop and implement an ISP to meet the resident's service needs. The facility may use the VDSS Model Form/ALF Individualized Service Plan, the UAI Plan of Care, or other facility-designated form as long as it meets the requirements of this section.

DMAS requirements for the completion of the ISP are as follows:

- The ISP must be completed by the appropriate parties and sent to DMAS as part of the admission certification process;

- The ISP must be completed in conjunction with the licensed health professional and monitored by the licensed health care professional at least quarterly for assisted living and at least monthly for intensive assisted living. The licensed health professional must sign and date the ISP for admission certification purposes; and

- A new ISP must be sent to DMAS for review every time the authorized level of care changes. This process will enable the provider to receive a revised payment tied to the level of care. The facility must follow the admission certification procedures. Failure to submit the revised level of care information in a timely manner may result in denial of DMAS payment for services provided or retraction of payment for a level of care the resident no longer needs.

The ISP must include the following:

1. A description of identified need from the UAI, physical examination reports, and any additional assessments necessary to meet the care needs of the resident and date identified;

2. A written description of services to be provided and who will provide them. List the tasks required to meet each service need/objective. These are the steps to take in order to solve the problem. Tasks will often involve obtaining a service for the resident. For each service, list the provider/type of staff that will provide the service;

3. When and where the services will be provided;

4. Expected outcomes/goals, including the time frame for accomplishing the measurable objectives. Each identified need should be written as a measurable objective, which is what the ALF and the resident want to achieve for each need. They are written in terms of a resident status that is observable or measurable so that the ALF and the resident will be able to tell when the outcome has been attained. A common error is listing a service rather than a resident status (e.g., improved functioning) as the measurable objective. In order to develop measurable objectives, the ISP must address the following questions:

    a. What is the problem that needs to be solved? For example, the following information is found from administering the UAI to Mrs. Jones:

        - Her lower dentures no longer fit;

- This limits her food intake;
- She has lost 10 pounds in 6 months; and
- She cannot afford to have her dentures fixed.

The problem statement is that Mrs. Jones is losing weight due to the lack of money to repair her dentures. The problem statement summarizes the identified needs.

b. How will staff know if the problem has been solved? The answer to this question should be written in terms of resident status that is observable or measurable so that both parties will be able to tell when the outcome has been attained. Some of the questions to ask are: Will the resident say or do something differently? Will staff be able to observe the resident doing something differently? Will the resident's environment look different?

In the example above, the measurable objective is: Mrs. Jones will receive new dentures and report eating solid foods regularly. When writing the objective, focus on short-term changes which can be seen and which will lead to long-term resolution of the problem. In this example, indicate on the ISP that staff will remove the apparent barrier to Mrs. Jones's ability to eat properly (obtain new dentures) and also state that staff will observe her eating solid food (which will logically lead to improved nutrition).

Each outcome should have an expected time frame for accomplishing the measurable objective. Record the date the task was accomplished. If the task was not accomplished, make a note of the reason.

5. The ISP must be signed by the resident or family, the licensed health care professional, and the licensee/administrator or designee and other persons as appropriate; and

6. For DMAS purposes only, the ISP must have the recipient's 12-digit Medicaid number and the ALF's seven-digit provider number.

Changes to the ISP

The ALF is responsible for making modifications to the ISP as needed to assure that the ALF staff and recipient/family are aware of the tasks to be performed and that the type of care is appropriate to meet the current needs of the recipient. The provider must designate a staff person to review, monitor, implement, and make appropriate modifications to the ISP. These changes must be initialed on the ISP and dated. That person must also keep the

resident's case manager and the facility's licensed health care professional informed of significant changes in the resident's conditions.

Any time the recipient's needs change, the ISP must be updated or a new ISP developed. The most recent ISP must always be in the recipient's record. The provider does not need to change the ISP to capture minor changes in tasks to be performed as long as the overall plan does not change. The ISP must be reviewed and updated at least once every 12 months.

Licensed Health Care Professional Responsibilities

Each ALF must retain a licensed health care professional, either by direct employment or on a contractual basis, to provide health care oversight to its assisted living residents. The VDSS regulations define "licensed health care professional" as any health care professional currently licensed by the Commonwealth of Virginia to practice within the scope of his profession, such as clinical social worker, dentist, licensed practical nurse, nurse practitioner, pharmacist, physical therapist, physician, physician's assistant, psychologist, registered nurse, and speech-language pathologist.

The licensed health care professional, acting within the scope of the requirements of his or her profession, must be on-site at least quarterly and more often, if indicated, based on his or her professional judgment of the seriousness of a resident's needs or the stability of a resident's condition for regular assisted living. On-site visits are required at least monthly for intensive assisted living residents. The responsibilities of the licensed health care professional while on-site must include:

1. Recommending in writing changes to a resident's ISP whenever the plan does not appropriately address the current health care needs of the resident;

2. Monitoring of direct care staff performance of health-related activities, including the identification of any significant gaps in the staff person's ability to function competently;

3. Advising the administrator of the need for staff training in health-related activities or the need for other actions when appropriate to eliminate problems in competency level;

4. Providing consultation and technical assistance to staff as needed;

5. Directly observing every resident whose care needs are equivalent to the intensive assisted living criteria and recommending in writing any needed changes in the care provided or in the resident's ISP;

6. Reviewing documentation regarding health care services, including medication and treatment records, to assess that services are being provided in accordance with physicians' orders, and informing the administrator of any problems; and

7. Reviewing the current condition and the records of restrained residents, assessing the appropriateness of the restraint and progress toward its reduction or elimination, and advising the administrator of any concerns.

A resident's need for skilled nursing treatments within the facility shall be met by facility employment of a licensed nurse or contractual agreement with a licensed nurse, by a home health agency, or by a private duty licensed nurse.

A licensed health care professional, acting within the scope of the requirements of his or her profession, shall perform an annual review of all the medications of each resident, including both prescription and over-the-counter medications. The results of the review shall be documented, signed, and dated by the health care professional and retained in the resident's record. Any potential problems shall be reported to the resident's attending physician and to the facility administrator. Action taken in response to the report shall also be documented in the resident's record.

VDSS has developed a model form, Record of On-Site Health Care Oversight for Assisted Living Residents, to document these requirements. This form will meet the documentation requirements of both DMAS and VDSS.

RELATION TO OTHER MEDICAID-FUNDED HOME-CARE SERVICES

Virginia currently offers two other home-based (non-waiver) services through the Virginia *State Plan for Medical Assistance*: home health and hospice care.

Home Health

ALFs must provide for certain services as mandated by the Department of Social Services' licensing standards for ALFs. When the ALF must provide home health nursing or aide services as a component of these covered services, DMAS will not reimburse a home health agency to provide such services to residents of ALFs. The ALF must provide the services as specified below, and the home health agency cannot bill DMAS for any of the specified non-reimbursable services. Prior to accessing home health services, the ALF must contact the MEDALLION PCP (Primary Care Physician) for a referral. If the recipient is in an HMO, the ALF should contact the HMO and follow the appropriate HMO guidelines for referrals.

The home health services that must be provided by the ALF and are not billable to DMAS or the recipient are:

- Home health aide services;
- Medication administration, including but not limited to:
  - By-mouth (oral) administration,
  - Insulin injections,
  - Eye drops,

- Rectal administration,
- Topical application,
- Inhalers, and
- Nasal administration.

- Medication monitoring; and
- Superficial wound care for pressure ulcers up to stage I-II or care to skin tears, minor cuts, or abrasions.

When injections other than insulin are necessary and ordered by the physician, the ALF must either administer the injection by appropriately licensed staff or assist the resident by securing the injection services through a home health agency, through an outpatient clinic visit, or through emergency services as most appropriate for the medical circumstance and reimbursement guidelines.

If a home health provider bills for or has billed for any of these services for a resident of an ALF, DMAS will deny or retract reimbursement for the inappropriate payments for such services.

In some cases, it is appropriate for home health skilled nursing to be offered to residents of ALFs. These cases only include services the ALF is not required to provide. Services requiring professional skills (such as tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique) cannot be performed by ALF staff. The skilled nursing care provided to the ALF resident shall not be for prohibited conditions described in this chapter.

Medicaid may cover skilled nursing services provided by a home health agency for less than 30 days. Personal care services provided by a home health agency will not be reimbursed. Medicaid cannot be billed for a home health aide and ALF staff providing identical services to the same recipient at the same time.

The above clarifications regarding the home health program are specific to home health nursing services and aide services only. ALF residents are eligible for home health rehabilitation therapies (i.e., physical therapy, occupational therapy, or speech-language pathology services) as long as the appropriate reimbursement criteria are met.

Hospice Care

Hospice is an autonomous, centrally administered, and medically directed program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and

during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization. To be covered, hospice services must be elected by the recipient, and his or her terminal illness (prognosis of six months or less) must be certified by the recipient's attending physician and the hospice medical director. A hospice must routinely provide a core set of services, which include nursing care, physician services, social work, and counseling. **The assisted living provider must contact DMAS prior to initiating service for any individual who is receiving hospice services.**

Prior to accessing hospice services, the ALF must contact the MEDALLION PCP for a referral.

RELATION TO THE MENTAL RETARDATION WAIVER

With the early implementation of the payment system supplementing the auxiliary grant for individuals requiring assisted living, DMAS advised providers that the level of care could overlap with services under the Medicaid Mental Retardation (MR) Waiver. Effective January 22, 1998, a federal mandate required that day support and day health and rehabilitation services, which were previously provided as State Plan Option Services, be placed under the MR waiver.

This change affects a number of the residents in assisted living across the Commonwealth. As a result of the impact on these residents and the providers who serve them, DMAS has reviewed the guidelines relating to overlapping services. The outcome is as follows:

- DMAS cannot authorize the supplemental payment for grandfathered into intensive assisted living services ($6.00 per day up to $180.00 per month) and pay for services under the MR waiver for individuals requiring both coverages.

- DMAS can authorize payment for Regular Assisted Living services ($3.00 per day up to $90.00 per month) concurrent with the services under the MR waiver. This is possible because the Regular Assisted Living services are not part of a waiver.

Intensive Assisted Living Recipients

As individuals currently authorized for intensive assisted living services (i.e., those grandfathered into the IAL level of care) are identified as having needs that can be met only through the services available under the MR waiver, the staff in the assisted living facility (ALS) and the staff from the local Mental Health/Mental Retardation Authority or Community Services Board (CSB) must work together. The individual, or his or her legally responsible representative, must be given sufficient information to make an informed decision about the program which will best meet the needs of the recipient. The individual, or his or her legally responsible representative, must sign a statement of choice, and copies of this signed statement must be maintained in the recipient’s file in the ALF and with the CSB.

Regular Assisted Living Services

ALFs with residents currently authorized at the regular assisted living level must have the computer-generated "permission to bill" letter. They must submit admission certification packages for all residents assessed at this level for whom they do not have this letter. Upon receipt of the "permission to bill" letter for the individuals who are also receiving services from the MR waiver, the ALF must submit completed claims clearly labeled and addressed as follows:

Facility and Home Based Services Supervisor
RAL/MR Claims
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Only those claims for individuals authorized for Regular Assisted Living Services and services under the Mental Retardation Waiver may be submitted to this address. Submit billing invoices for all other Auxiliary Grant residents as instructed in Chapter V of this manual.